

Patient Information

Last name:	First name:	MI:	DOB:	<input type="radio"/> Male	<input type="radio"/> Female
Home address:		City:	State:	ZIP:	
Billing address: <input type="checkbox"/> Same as home.		City:	State:	ZIP:	
Phone #1: ()	<input type="radio"/> Home	<input type="radio"/> Work	<input type="radio"/> Cell	Phone #2: ()	<input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell
Email Address:	I authorize Qliance to email me regarding my medical care: <input type="radio"/> No <input type="radio"/> Yes				
Emergency contact:	Phone: ()	Relationship:			
Known allergies:	Current Medications:				
Do you take medications regularly for pain, anxiety, sleep or ADD? <input type="radio"/> Yes <input type="radio"/> No					
<i>Please Note: If you are taking a controlled substance regularly for any of these conditions, please see our controlled substance policy at www.Qliance.com or request a copy from Member Services to make sure that Qliance is right for you.</i>					

Membership

Membership Start Date: <i>(Upon receipt unless otherwise specified.)</i>	Qliance Service Level: <input type="radio"/> Level 1 <input type="radio"/> Level 2
Preferred clinician and clinic location:	<input type="radio"/> Downtown Seattle <input type="radio"/> Kent Station <input type="radio"/> Mercer Island <input type="radio"/> Tacoma
How did you hear about Qliance?	<input type="radio"/> Personal Referral: <input type="radio"/> TV/Radio:
<input type="radio"/> Internet:	<input type="radio"/> Print Publication: <input type="radio"/> Other:
Do you have medical insurance? <input type="radio"/> Yes <input type="radio"/> No <i>If yes, please bring your ID card to your first visit so that we may expedite referrals and outside lab testing.</i>	

Billing

Billing Frequency: <input type="radio"/> Annually <input type="radio"/> Semi-Annually <input type="radio"/> Quarterly <input type="radio"/> Monthly		
• OPTION A: Credit Card or Debit Card		
Name on card:		
Card type: <input type="radio"/> Visa <input type="radio"/> MasterCard <input type="radio"/> American Express	Card number:	Expiration:
Card billing address: <input type="checkbox"/> Same as home.		
<input type="checkbox"/> Yes, please add me to the billing account of an existing Qliance patient associated with the above credit card:		
• OPTION B: Automatic Funds Transfer		
<i>Please note it takes approximately 3 days from the payment processing date before the charge posts to your bank account.</i>		
Name on account:		
Bank name:	Account type: <input type="radio"/> Checking <input type="radio"/> Savings	
Account number:	Bank routing number: <i>(please attach a voided check to this form)</i>	

Authorization

Your child's monthly care fee covers the services described in the Qliance Patient Services Guide. At times, however, your child's care may require durable medical supplies or third-party services that are not covered by the monthly care fee. To streamline your child's appointment check-out, please note that by providing the above billing information you authorize Qliance to automatically charge your card or draw on your bank account for any incidental items at the time of service. In all cases, incidental items are charged at or near our cost and will be discussed with you in advance.

- By signing below, I hereby authorize Qliance to contact me using the information I have provided above. By signing below, I hereby authorize Qliance to initiate charges to my credit card, debit card or bank account for my child's periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my child's care fee plus the care fees of any individuals on my account.
- This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until Qliance has received written notification from me of its termination in such time and in such manner as to afford Qliance and my financial institution a reasonable opportunity to act on it.
- I understand that my child's participation in Qliance is continuous and that, by signing below, I authorize recurring credit/debit card charges.
- I understand that a \$25 fee will be charged to me for declined credit, debit card or automatic funds transfer transactions that are not honored.

ACCOUNT HOLDER SIGNATURE: _____ **DATE:** _____

OFFICE USE ONLY				Date:
Patient number:	Billing number:	Registration fee: \$	<input type="checkbox"/> MRT <input type="checkbox"/> MHF	

- I acknowledge and understand that I am voluntarily enrolling my child as a Qliance Medical Group of Washington PC (“Qliance”) patient and that this agreement is non-transferable.
- I have reviewed the *Qliance Patient Services* guide and I have had the opportunity to ask questions and receive answers regarding its content.
- I acknowledge and understand that **this agreement does not provide comprehensive health insurance coverage** nor is it a contract of insurance and that **it provides only the health care services specifically described** in the *Qliance Patient Services Guide*.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of Qliance including but not limited to emergency room, hospital and specialty services and that Qliance will not bill insurance carriers for any services provided by Qliance.
- I acknowledge and understand that Qliance must maintain a record of my child’s health information and must protect the privacy of my child’s health information as per the terms of the *Notice of Privacy Practices*. I understand and acknowledge that this policy is available for my review at any time at www.Qliance.com or upon request.
- I acknowledge and agree to pay my child’s monthly care fee on or before its due date. In the event that I am unable to pay my child’s fee(s) on time, I understand that I will be charged a \$25 late fee and that my child’s service agreement may be terminated.
- I acknowledge and understand that I may terminate this *Patient Agreement* at any time and for any or for no reason by providing written notice to Qliance. **Monthly fees will continue to accrue until written termination notice is received.** Any pre-paid monthly care fees will be prorated to the date Qliance has received my written termination and refunded to me within ten (10) business days.
- In addition, I acknowledge and understand that Qliance may terminate this *Patient Agreement* by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and refunded to me within ten (10) business days. Qliance will not terminate this *Patient Agreement* solely on the basis of health status.
- I acknowledge and understand that Qliance may add or discontinue services or may increase my child’s fee schedule at any time (but no more than once per year), and that I will be given, in writing, at least sixty (60) days notice of such fee schedule changes.

Rights & Responsibilities

- I understand that I have the right to choose my child’s personal health care clinician and to change his/her clinician at any time, for any reason. I understand that all reasonable efforts will be made to accommodate my request, but only if my child’s new clinician’s patient panel is open to new patients.
- I understand that I have the right to receive accurate and easily understood information about Qliance’s health care services, health care professionals and health care facilities. If my child or I speak a language different from his/her clinician, have a physical or mental disability or do not understand something, I understand that Qliance will make its best effort to provide assistance so I can make informed health care decisions. If my child or I require interpreter services beyond what can be provided by Qliance, professional interpreters may be provided at an additional cost to me.
- In the event of membership termination, I understand that I must complete a **written Service Cancellation Form**. Any differences in payment between my billing date and the date of cancellation will be refunded to me via the payment method I have chosen for my child’s monthly care fee. I understand that if my child’s account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my child’s Qliance health care clinician(s), and other Qliance staff. I also understand that I am responsible for communicating clearly and respectfully with my child’s clinician and other Qliance staff. Should I become dissatisfied with my child’s care or Qliance services, I agree to notify Qliance immediately so my concerns may be addressed in a timely manner.
- I understand that I have the right to know all of my child’s treatment options and to participate in my child’s health care decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions.
- I understand that I have the right to speak in confidence with my child’s Qliance clinician(s) and to have my child’s health care information protected. I understand that Qliance will not disclose my child’s information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my child’s personal medical record and may request that my child’s record be amended if I feel it is inaccurate or incomplete by contacting the Qliance HIM Department.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my child’s health care clinician(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities. I agree to first bring any complaints to the attention of Qliance staff and to participate in the Qliance complaint and grievance process. Unresolved complaints may be brought to the attention of the Office of the Insurance Commissioner for the State of Washington by calling the Consumer Advocacy department at: (800) 562-6900 (TDD 360-586-6241) or by email at cad@oic.wa.gov.
- In order to receive the best possible care, I agree to be actively involved in my child’s health care decisions and to disclose all relevant information to my child’s Qliance health care clinician(s) so that they can help my child achieve their health goals. I also agree to inform my child’s Qliance health care clinician(s) of any health care services my child receives outside of Qliance (such as emergency room, specialist, or hospital services).
- I understand that I am responsible for not exposing myself, my child or others to disease or danger. I understand that I can receive information from my child’s Qliance health care clinician(s) about protecting the health and safety of myself and others.

By my signature below, I agree to my child becoming a Qliance Medical Group patient and I agree to the terms outlined in this Patient Agreement.

SIGNATURE:

DATE:

PRINT NAME:

SIGNATURE BY: Patient Parent Legal Guardian

NAME:	DOB: <i>mm/dd/yyyy</i>	DATE:
Mother's name:	Father's name:	Other parent's name:
Who does your child live with?		

Health Assessment

What is most important to you about the medical care of your child? (<i>e.g. communication, prevention, wellness planning</i>)
What specific concerns about your child would you like to address with their new clinician?

Medications & Allergies

Please list all your child's current medications (<i>including vitamins & supplements</i>).				
Item	Dose	Frequency	Taken for	Prescribed by
1.				
2.				
3.				
Allergies to medications and other items:				
1.			Reaction:	
2.			Reaction:	
Preferred pharmacy:		Phone:		Fax:
Address:				

Social History & Lifestyle

Daycare/Nanny? <input type="radio"/> Yes <input type="radio"/> No	School:	Grade:
Any problems at home/school/daycare (<i>i.e. learning, behavioral etc.</i>)?		
Who lives at home with your child?		
Are there any pets in the home? <input type="radio"/> Yes <input type="radio"/> No If yes, type:		
Diet (<i>infants</i>): <input type="radio"/> Breastfeeding <input type="radio"/> Formula <input type="radio"/> Solid foods		
Diet (<i>children or adolescents, please describe</i>):		
Exercise or Activities		
Type:	No. of days per week:	
Type:	No. of days per week:	
Type:	No. of days per week:	
Does anyone smoke in the home? <input type="radio"/> Yes <input type="radio"/> No		
If your child is less than 4'9", does he/she use a car seat (booster seat)? <input type="radio"/> Yes <input type="radio"/> No		
If your child is under age 13, does he/she ride in the back seat of the car? <input type="radio"/> Yes <input type="radio"/> No		
Do you feel safe in your neighborhood? <input type="radio"/> Yes <input type="radio"/> No		
Are there guns in your home? <input type="radio"/> Yes <input type="radio"/> No	If yes, are they unloaded and locked away? <input type="radio"/> Yes <input type="radio"/> No	
Is there any history of abuse in your child's home or life (<i>physical, sexual, emotional, neglect</i>)? <input type="radio"/> Yes <input type="radio"/> No		

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NAME:	DOB:
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Health Maintenance & Prevention

When was the last time your child:	
Had a well-child exam?	Visited the dentist?
Female Health	
Has your child started her period? <input type="radio"/> Yes (<i>Age</i>) <input type="radio"/> No	
Has your child had a PAP smear? <input type="radio"/> Yes <input type="radio"/> No	
If yes, when? <i>mm/yyyy</i>	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal
Immunizations	
Are your child's immunizations current? <input type="radio"/> Yes <input type="radio"/> No	

Personal Medical History

Pregnancy complications:	Delivery complications:
Delivery method: <input type="radio"/> Vaginal <input type="radio"/> C-section	Birth weight:
Multiple births (<i>twins</i>): <input type="radio"/> Yes <input type="radio"/> No	
Has your child ever had any problems with the following: (<i>If yes, please explain.</i>)	
<input type="checkbox"/> Alcohol or substance abuse:	<input type="checkbox"/> Lungs:
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Metabolism (<i>diabetes, thyroid etc.</i>):
<input type="checkbox"/> Blood:	<input type="checkbox"/> Muscle, joint, bones:
<input type="checkbox"/> Digestion:	<input type="checkbox"/> Nerves and brain:
<input type="checkbox"/> Ear, nose, throat, eyes:	<input type="checkbox"/> Skin and hair:
<input type="checkbox"/> ER Visits: Type: Date:	<input type="checkbox"/> Sleep:
<input type="checkbox"/> Heart or blood vessels:	<input type="checkbox"/> Social, mental or emotional health:
<input type="checkbox"/> Hospitalizations: Type: Date:	<input type="checkbox"/> Surgeries: Type: Date:
<input type="checkbox"/> Infectious diseases:	<input type="checkbox"/> Female health (<i>menstrual problems, etc.</i>):
<input type="checkbox"/> Kidneys or bladder:	<input type="checkbox"/> Male health (<i>testicular lump/pain</i>):
<input type="checkbox"/> Learning disabilities:	<input type="checkbox"/> Other:

Family Medical History

Please indicate any family members who have had the following:		
<input type="checkbox"/> Alcohol abuse:	<input type="checkbox"/> Bleeding disorders:	<input type="checkbox"/> Deafness:
<input type="checkbox"/> Arthritis:	<input type="checkbox"/> Breast cancer:	<input type="checkbox"/> Dementia:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Cancer of an unknown type:	<input type="checkbox"/> Depression:
<input type="checkbox"/> Autism:	<input type="checkbox"/> Colon cancer:	<input type="checkbox"/> Diabetes:
<input type="checkbox"/> Bipolar disorder:	<input type="checkbox"/> Cystic fibrosis:	<input type="checkbox"/> Glaucoma:
<input type="checkbox"/> Heart attack:	<input type="checkbox"/> Lymphoma/Leukemia:	<input type="checkbox"/> Schizophrenia:
<input type="checkbox"/> Heart disease:	<input type="checkbox"/> Osteoporosis:	<input type="checkbox"/> Sickle cell anemia:
<input type="checkbox"/> High blood pressure:	<input type="checkbox"/> Ovarian cancer:	<input type="checkbox"/> Skin cancer:
<input type="checkbox"/> High blood cholesterol:	<input type="checkbox"/> Obesity:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> HIV:	<input type="checkbox"/> Parkinson's disease:	<input type="checkbox"/> Substance abuse:
<input type="checkbox"/> Inherited anemias (<i>i.e. thalassemia</i>):	<input type="checkbox"/> Prostate cancer:	<input type="checkbox"/> Thyroid:
<input type="checkbox"/> Inflammatory bowel disease (<i>e.g. Crohn's disease</i>):	<input type="checkbox"/> Other cancer:	
<input type="checkbox"/> Any other condition that two or more relatives have?		

Please attach your child's immunization record to this form.



Health History Survey *Optional*

This section describes the care your child received prior to joining Qliance. Please score the following questions using a scale of 0-10, with 0 being strongly disagree and 10 being strongly agree. These questions are *optional* and the answers you provide are confidential.

	Score (0-10)
My child has been able to get care from his/her primary care clinician when and how they need it.	
My child has had a personal health care provider (doctor, nurse practitioner etc.) who knows them as a person.	
The bulk of my child's health care needs have been met by their primary care provider's office.	
My child's primary care clinician has coordinated their care throughout the health care system.	
When my child has visited their primary care provider's office, it has been organized and efficient.	

Patient Self Health Assessment

How do you rate your child's health? <input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good <input type="radio"/> Very Good <input type="radio"/> Excellent	
During the past 4 weeks, how much trouble has your child had engaging in their usual activities because of their physical or emotional health? <input type="radio"/> No difficulty <input type="radio"/> A bit of difficulty <input type="radio"/> Some difficulty <input type="radio"/> Much difficulty <input type="radio"/> Could not engage in usual activities	
During the past 4 weeks, how much school or activities has your child missed due to physical or emotional problems? <input type="radio"/> Not at all <input type="radio"/> 10-20% <input type="radio"/> 21-30% <input type="radio"/> More than 30%	
During the past 4 weeks, has your child's physical or emotional health limited their social activities?	<input type="radio"/> Yes <input type="radio"/> No
In the past 3 months has your child had any injury or illness that has kept them in bed for all or most of the day?	<input type="radio"/> Yes <input type="radio"/> No
In the past year, has your child gone to the ER for care?	<input type="radio"/> Yes <input type="radio"/> No
In the past year, has your child stayed in the hospital overnight or longer?	<input type="radio"/> Yes <input type="radio"/> No